Canada Life

Attending Physician's Statement - Disability Benefits

Instruction:
1. Please print.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. **Any charge for completion of this form is the patient's responsibility.**

Part 1: Patient Authorization

Name:		Date of Birth:	
I, _____ hereby authorize the release to my insurer any information including consultation reports and tests with respect to this claim.			
Patient Signature:		Date (dd/mm/yy)	

Part 2: Attending Physician's Statement

Primary Diagnosis (please use DSM IV Criteria for mental/psychiatric conditions) :				
Additional Conditions or Complications:				
Subjective Symptoms (including severity and frequency):			**Current GAF Score** (Global Assessment of Functioning)	
Objective findings on examination:				
Date of latest attendance (dd/mm/yy)		Hospital Admission and Discharge Dates (dd/mm/yy)		
Current prescribed medications and dosages:				
Name				
Initial Dose				
Current Dose				
Date of Last dose change				
Other treatment (e.g.: physiotherapy, counselling, etc.):				
Future treatment plans (e.g.: pending referrals, imaging, surgeries):				

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Name:		Date of Birth:	

Expected Recovery / Return to Work date:
Can your patient return to work on gradual basis or any other occupation at this time?
Prognosis for recovery:

Current functional Limitations				
Function:	**Degree of Limitation**			
	None	Slight	Moderate	Severe
Cognition				
Speaking				
Hearing				
Vision				
Psychological				
Sensation				
Dexterity				

Activity:	**Degree of Limitation**	
	Duration / Weight	Frequency
Driving		
Walking		
Standing		
Climbing		
Sitting		
Bending		
Lifting		
Dexterity		

Additional Comments:

Name of Attending Physician (please print)	Specialty:	Telephone:
Address		
Signature of Physician		Date (dd/mm/yy)